TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GREGORY P. ENNIS, MD

Respondent Name
ARCH INSURANCE CO

MFDR Tracking Number
M4-15-2311-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MARCH 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "that Per rule 133.210 'Medical Documentation' paragraph (e); 'It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other.' Gallagher Bassett's lack of payment based on lack of narrative of the submitted claim is therefore in err."

Amount in Dispute: $476.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined no further payment is due."

Response Submitted By: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 10, 2014	CPT Code 99214 Office Visit	$188.49	$0.00
	CPT Code 99080-73-RR Work Status Report	$15.00	$0.00
May 8, 2014	CPT Code 99215 Office Visit	$257.71	$0.00
	CPT Code 99080-73-RR Work Status Report	$15.00	$0.00
TOTAL		$476.20	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §133.307, effective June 1, 2012 sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29-The time limit for filing has expired.
   - 18-Duplicate claim/service.
   - 112, 11-Service not furnished directly to the patient and/or not documented.
   - W3-Request for reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Did the requestor support position that the disputed bills were submitted timely?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "29."

Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.'

28 Texas Administrative Code §102.4(h), states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

The requestor did not submit any written communication outlined in 28 Texas Administrative Code §102.4(h) to support position that the disputed bill was sent timely to the respondent. The Division finds that the requestor has not supported position that bill was submitted in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		06/10/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.